Bellini Pilates
PERSONAL TRAINING

Heath History/Par-Q Form 2013

Name: _____ Age: Sex: #: ( ) - Email: _____

Address: _____ DOB: / / Height: Weight: _____

Any medical complaint? _____ Yes/No

Have you ever been hospitalized, treated for serious illness or had surgery? Date: / / _____ Yes/No

Have you had a recent surgery? _____ Yes/No

Have you had major surgery or an injury that might hinder or prohibit your participation in an exercise program? _____ Yes/No

Are you currently under a physician's care for any physical health problem? _____ Yes/No

Are you aware of any problems that would keep you from participating in regular vigorous physical activity? _____ Yes/No

Are you presently talking any medication (prescription & nonprescription)? _____ Yes/No

- What is this medication for and how does it affect your ability to exercise or achieve your fitness goals? _____ Yes/No

Do you have any drug allergies? _____ Yes/No

Do you have any chronic illnesses or physical limitations such as Asthma or Diabetes? Yes/No

Do you have any injuries or orthopedic problems such as broken bones, bursitis, tendinitis, arthritis, bad knees, back, shoulder, wrist or neck issues? Please specify _____ Yes/No

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activities? Yes/No

Do you ever have pains in your chest when preforming physical activity? Yes/No

Have you had chest when you were not doing physical activity? Yes/No

Do you lose your balance due to dizziness or do you ever lose consciousness? Yes/No

Are you pregnant now or have you given birth within the last 6 months? Yes/No

Do you smoke? If yes how many per week? _____. Yes/No

Do you drink alcohol? If yes how many per week? _____.

How many hours do you sleep at night? _____.

Describe your job: Sedentary Active Physically Demanding

How would you rate your stress level? Very Low 1 2 3 4 5 6 7 8 9 10 Very High

Is anyone in your family overweight? Mother Father Sibling Grandparent

Were you overweight as a child? Yes/No if yes, at what age?

Do you have, or recently experienced, or ever had (check all that apply)?

- o Rheumatic fever
- o High cholesterol
- o High blood pressure
- o Infections
- o Aneurysm
- o Asthma
- o Embolism
- o Stroke
- o Diabetes
- o Edema/swelling
- o Pneumonia
- o Increased anxiety
- o Emotional disorder
- o Heart attack
- o Stomach problems
- o Hernia
- o Limited joint movement
- o Shoulder problems
- o Ulcers
- o Anemia
- o Heart murmur
- o Thromgophiebitis
- o Angina / Chest pain
- o Respiratory discomfort
- o Fixed rate pacemaker
- o Fixed rate pacemaker
- o Epilepsy / seizures
- o Shortness of breath

Do any of your immediate family have a history of (check all that apply)?

- o Heart disease
- o Heart surgery
- o High cholesterol
- o Diabetes
- o Heart attack
- o Congenital heart disease
- o High blood pressure
- o Stroke
- o Premature death

In case of emergency, please contact:

Name _____ Phone _____.

Participant under the age of 18:

Signature of Parent/Guardian _____.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name _____ Date ___/___/___.